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ABSTRACT

A general look at the drug abuse problem comprises the first part of the paper. The author views drug abuse in terms of dependence rather than addiction, and as being either physiological or psychological. He briefly discusses which drugs are used, by whom, and for what purposes. Drug abuse is seen as an old problem with contemporary manifestations which are spelled out. Two approaches for dealing with the problem are considered: (1) treatment of those already drug-dependent, and (2) prevention of others from becoming drug-dependent. The primary focus is on prevention, which is considered a total community problem because it necessarily involves youth and adults. The thrust of prevention should be: (1) making nonusers aware of the potential dangers of drug abuse, and (2) enlisting them to help peer group members who are users. The author encourages classroom drug education, effective law enforcement, dissemination of information concerning the legal penalties for selling or possessing dangerous drugs, and community-wide coordinating committees for planning programs and avoiding duplication of services. (TL)

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# REMARKS

BY

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Before

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and

Juvenile Agencies

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There is no doubt that the abuse of the dangerous drugs is on the increase among our youthful population. The increasing evidence of the past year indicates that this is no passing fancy. In New York State, we have been saying that in any secondary school or college in the state where drug abuse had begun to occur, no one should be surprised to find 20 to 30 percent of the student population either using or experimenting with drugs. Recently, students have been telling us that this should be quoted as 40 percent of the student population, with particular emphasis in the rise in the smoking of marijuana. It may be that on some college campuses in New York State the percentage of student involvement is even higher.

It is important to remember that we are not talking about the proper use of drugs. The accelerating discovery of whole new spectrums of drugs has been a great help to the medical profession, saving the lives of many people who ten to fifteen years earlier would have died.

It is the misuse and abuse of these drugs which is causing our present difficulties; misuse meaning using the drug for purposes for which it was not intended in medical practices and abuse meaning using the drug in quantities that are considered beyond the medically prescribed limits of safety.

It will be helpful in our discussion to talk of drug abuse in terms of drug dependence rather than addiction. Drug dependence can be either physiological or psychological. In this sense, narcotic addiction is a drug dependence of the physiological type and marijuana is a drug dependence of the psychological type. In the first instance, the body

requires the drug in order to prevent withdrawal symptoms and in the latter the drug becomes a crutch to the personality. The importance of this type of definition comes in discussions with students where the tendency is to consider addiction as being only the physiological type associated with the narcotic drugs and, therefore, if a drug does not create a physiological dependency, it is not addicting. In this way, students justify their smoking of marijuana since it is not physiologically addicting, they reason that it is not harmful to them.

What drugs are being abused today? The main drugs of abuse are of two types. One is the "hard" drugs being opium and any of the natural or synthetic derivatives, particularly heroin and second, the "soft" drugs which include the amphetamines, barbiturates and hallucinogens, particularly marijuana and LSD. Statistics of the Federal Bureau of Narcotics indicate that there are approximately 90,000 narcotic addicts in the United States of which approximately 50 percent are in the State of New York, 90 percent of whom can be found in the metropolitan area of New York and a portion of the remainder in Buffalo. The Division of Research of the Narcotic Addiction Control Commission has recently determined that the estimate for narcotic addicts in the State of New York would be closer to 50,000.

There are no adequate statistics on the abuse in the population of the so called "soft" drugs, but every clinical experience seems to indicate that the abuse of these drugs is more serious than narcotic drugs and that the adult population is particularly involved in this type of drug abuse. Some researchers are estimating one out of every

four adults using amphetamines, barbiturates and tranquilizers. It may well be true that, in the long run, the abuse of the narcotic drugs may not be the most serious drug abuse problem for our population, even though heroin addiction has led to the large scale crime against property in our society. Increasingly we are going to have to deal with "soft" drug abuse and it is well for us to understand that when we find this type of abuse, we should be as concerned as when we find narcotic addiction. There is nothing easy about these drugs. Barbiturates create a physical dependency and overuse can lead to convulsions and death. Amphetamines, intravenously administered, can "kill."

Heroin appears to be the drug of choice for abuse in the disadvantaged areas of our State and the "soft" drugs, the drug of abuse of our white, middle-class suburban and rural communities. The choice of the drug is related to the nature of the group's unsolved problems. The ghetto youth sees no way of escaping from the intolerable conditions of their neighborhood and no educational or employment future. The drug of choice is one that would completely remove them from the reality of these intolerable conditions. The opium-type drug, heroin, does this better than any other drug. For those middle-class suburban youth who are searching for personal identity and do not find this in their middle-class economic surroundings, the desire is to look inward. The drugs which helps them do this are the hallucinogens, the so-called "mind-expanding drugs."

Drug abuse today is considered a socially infectious type of disease, one which is transmitted by teaching or imitation from one individual to another. The theory that drug abuse begins with the pusher selling to the user has long since been discarded. The importance in discarding the pusher theory is that it makes each community aware that the source of infection comes from within the community and must be attacked, otherwise there is the possibility for an endemic spread of drug abuse in the community. One acquires a habit of drug abuse frome one's social group, friends, neighbors and acquaintances, not from the outsider who comes into the community to sell drugs.

We have learned that drug abuse has no boundary lines. It has affected the white population as well as the Negros and Puerto Ricans. It crosses all economic classes and is occurring in both the Negro-Puerto Rican ghetto areas and the white, middle-class suburban and rural areas. No one and no area is immune to this type of disease.

Drub abuse has been known throughout the history of civilization. We are not dealing with a new problem. What we do have are some serious manifestations of drug dependence as it occurs in our modern society. Let's examine what happens with narcotic addiction today.

The first factor is the decrease in the age of the affected population. Whereas narcotic addicts used to average between 30 to 35 years of age, today in our state rehabilitation centers, the average age of the narcotic addict is from 17 to 25. The second factor is the early drop-out from education. The average educational age of a narcotic addict is 7½ years, less than a grammer school diploma. One can understand the

seriousness of this when a rehabilitated narcotic addict tries to get reemployed in our highly technological society. The third factor is the prevalent pattern of the mixture of drugs. The tendency of most people is to think that drug dependent individuals abuse only one type of drug. They use all types of drugs. Not only at different times, but they combine them. For example, heroin and barbiturates are mixed to try to produce an "even" high. It is important to understand that drug dependent individuals use the entire gamut of the hard and soft drugs, moving from one to another in order to secure a more favorable degree of intoxication and to substitute drugs, even alcohol, when either the finances of the individual are low or the supply of certain drugs has tightened. The fourth factor is the total loss of the individual as a productive member of his family and his community. The continual search for the heroin drugs becomes an all prevading daily responsibility leaving no time for work or family responsibilities. The fifth factor is the destruction to the family both economically and psychologically. The narcotic addict steals from his family in order to satisfy his need for a purchase of drugs and brings social disgrace on the members of his family. The sixth factor is the loss to the community in terms of the crime against property. It is estimated that in the City of New York alone, a half a billion to a billion dollars a year of property is stolen by narcotic addicts in order to be fenced to secure funds for drug purchases. And the seventh factor is the involvement of other members of the community in this drug dependent disease because the stolen goods must be purchased by members of the community in order to supply the necessary funds.

As yet, there is no scientific evidence to indicate that drug abuse stems from a biological factor or chemical imbalance. As a result, we know of no medical counter-measures which will eliminate the need for the abuse of a drug. Therefore, we approach the problem of drug abuse as an indication of character-disorder problems in which drugs are used to attempt to solve unsolved problems. In this context, drug abuse is considered to be a symptom of underlying difficulties in either the personal or social situation of the individual drug abuser.

It would be a mistake to think that only students abuse drugs. Adults equally abuse drugs. The mother who overdoes the use of diet pills and tranquillizers and the father who relieves his job tensions through the overuse of alcohol and tobacco has not only used drugs to solve their own personal problems, but by a social example has probably contributed to their children's acceptance of their own use of drugs. Here we face one aspect of alienation when youth says that their adult parents are hypocritical because they have been willing to legalize their drugs of abuse, being alcohol and tobacco, and are unwilling to legalize youth's drugs, marijuana.

A program of drug abuse education which appears to center on youth alone, will be turned off by the students because they do understand that in their homes drugs are abused equally by their parents.

It is important for workers in juvenile agencies to understand that youth are seriously involved in drug abuse, but to equally understand that their adult parents are also involved and are inherently part of the problem of trying to work with the youthful population.

How can we make an approach toward handling this serious public health problem? There are two mutually dependent methods; through the treatment of those already drug dependent and through the prevention of others becoming drug dependent. We have found in other public health problems that resources of money and manpower have been absorbed in helping those already ill and have left little for developing the techniques of prevention. We must be sure this does not happen in the field of drug dependence. It is surely true that the problem will not be handled by treatment alone of the ill or the sick. In the State of New York, for example, where the largest program for the treatment of narcotic addicts in the world now exists, only 1/7 of the total known population of addicts is now under treatment and I am sure that without preventive measures, more individuals will become heroin drug dependent before we have successfully completed the rehabilitation of the present addicts in the State of New York. Therefore, prevention must be tackled in its own rights and with the understanding that techniques in treatment may not be automatically techniques for prevention.

This separation allows us to identify the proper population target of each method. I would say that the target population for treatment are those who are already drug dependent and the target population for prevention are the "non-users" who are not yet drug dependent. This, I think, is a very important distinction, because too long have we found that communities would only identify as having a problem if they could be shown that they already had youth who were abusing drugs. They did not consider that there was a problem of helping to fortify those who were not using drugs against the future abuse of drugs.

For juvenile agencies, therefore, their main role is treatment and their clients, those who have become ill from drug dependence. I suggest that in most cases other agencies will have to be established in the community to concentrate on preventive methods because most of our treatment agencies today will be thoroughly absorbed in the drug abusers.

A word about the role of the "ex-addict" in this problem of drug dependence. A great caution is needed here on using ex-addicts. The "guilty community" is too prone once it shows a willingness to get at the problem to look for one-shot solutions and are too quick to accept the glib ex-addict's indication of his expertise as the immediate solution to their problem. It has been my experience that ex-addicts have a usefulness as an image only with drug dependent individuals. Their experience and interest really does not move in the direction of the "non-user" and they tend in communities to search only for the users and experimenters. For the user they are an ideal image because they point out from their personal experience that once having become drug dependent, one can stop using drugs and become rehabilitated. I suggest that the ex-addict is not the proper image for the "non-user" for whom we want to suggest alternate methods of being able to solve personal problems without going through the drug dependent route. I urge a selective use of "ex-addicts" and always under professional supervision.

As the head of the Division of Narcotic Education of the New York State Narcotic Addiction Control Commission, I am naturally most interested in the problem of prevention. Drug dependence cannot be considered as a youthful problem alone. It must be considered a total community problem because it involves both youth and adults.

The goal for drug abuse education should be to prevent students and adults from dropping into the pattern of drug abuse resulting in addiction. Experience with the narcotic addict has certainly taught us that once addicted, rehabilitation is a long, difficult, and expensive process. If our goal is prevention, then the basic target population should be the present "non-users" of drugs. The inoculation of the non-user with the kind of social attitudes which will result in the mature decision that drugs will not be used as an attempt to solve personal and social problems should fortify the non-user from the peer group pressures that will attempt to encourage them to experiment with drugs.

The user and the experimenter certainly need our counseling help, but the preventive program cannot be simply geared toward them since this is too late in the time schedule for the proper inoculation against the abuse of drugs. The normal professional tendency is to look first to help the "sick ones." I think this is the wrong approach for prevention. In any long-range educational program of drug abuse for non-users, users and experimenters will have a better climate in which to surface and be recognized and given proper counseling aid.

Working with the non-using peer group should be two-fold: first, to make them aware of the potential dangers of drug abuse, and second, to enlist them in accepting a social responsibility for trying to bring their using peer group members back into their social circles. It is important for non-users to understand that not only do drugs lead to no satisfactory solution to problems but they often add additional personal difficulties that arise

from the use of drugs themselves. It is not enough for these non-users to be fortified against their personal movement in a drug abuse direction but they need to accept a social responsibility for their fellow students. Here I see the greatest possibility for the future if a "peace corps against drug abuse" were organized among the student groups themselves.

Education for prevention is a long-range problem. One shot approaches, overnight solutions, are not going to be effective. We must help students be aware of the nature of drugs, their use, and the effects of their abuse on the individual. Effective understanding of drugs and attitudes toward drug use must begin very early in the students' education program. This is where the educational system and the school teacher can make an effective contribution to the prevention of drug abuse.

The New York State Legislature has now mandated a new health education curriculum in which Strand II, the Sociological Strand, will concentrate on the problem of drugs, alcohol and tobacco, from Grade 4 to Grade 12. This eight year program should effectively condition our student group to the elimination of drug abuse. It is mandated to be in all schools in the State of New York by 1970.

In the meantime, the drug abuse problem is with us and the long-range program must be supplemented by a "first aid" type program in order to intervene in the present drug abuse scene among students. This is especially necessary for elementary and high school students who may not as yet have had the benefit of discussions on drug abuse.

Today, knowledge of drugs and their abuse are being learned on the streets and it is much better that we begin to open up these discussions in the classroom in an objective, unemotional manner. It is important that the problem begins to be discussed from teacher to student and student to student and to bring it out of the school washroom and the uninhabited tenement house. This public discussion of the problem in the classroom and by the adults in the community is the most important immediate contribution that can be made to helping non-users from getting involved in drugs.

Law enforcement can contribute indirectly to prevention. Detection and removal of the sources of the illegal drug supply will make it difficult for the casual experimenter for kicks or thrills to become started in the drug scene.

In presenting material to students, I feel that it is part of the educational process that a clear-cut understanding of the penal laws on dangerous drugs be brought to the attention of students. They should be aware of the degree of severity of these penalties and the difficulties which may come to them when these laws are broken, such as difficulty in getting into a college, finding a job, going into a profession, and obtaining a civil service position. These are facts which a student must have and be aware of as he comes to making his own independent judgment as to what direction he will move in in relation to drug abuse.

A community wide committee is the necessary organizational form for handling the complete problem of preventive education in a community. In New York State we now have a vehicle for the coordination of all these efforts. The municipalities laws have been amended to provide for the formation of local Narcotic Guidance Councils either at the village, city, town, or county level. These councils have

the total responsibility for planning a community wide program, coordinating it and avoiding duplications of services.

Those five member councils co-op to themselves 45 to 50 key volunteers including the social agencies and together become the task force for the total approach to the community's drug dependence problem. The councils have the responsiblity of the education for prevention and for the counciling of non-narcotic drug dependent individuals. The narcotic addicts are treated in the State's rehabilitation centers.

I would urge all of the agencies present today, to urge this type of local council or committee in their home communities.

Controlling the problem of drug dependence requires the total effort of all agencies and citizens in a community. This is a problem that cannot be solved by the established agencies alone because every individual in the community is potentially a dropout to drug dependency, and every family and every non-user is needed to help the drug dependent individual become self-sustaining again. Volunteer involvement is vital and without it we will lose the fight.

NEW YORK STATE REVISED PENAL LAW 9/69

# PENALTIES FOR SALE OR POSSESSION OF NARCOTICS

## ARTICLE 220 - DANGEROUS DRUG OFFENSES

Sec.


220.00 Dangerous drug offenses; definitions of terms.
220.05 Criminal possession of a dangerous drug in the sixth degree.
220.10 Criminal possession of a dangerous drug in the fifth degree.
220.15 Criminal possession of a dangerous drug in the fourth degree.
220.20 Criminal possession of a dangerous drug in the third degree.
220.22 Criminal possession of a dangerous drug in the second degree.
220.25 Criminal possession of a dangerous drug; presumption.
220.30 Criminally selling a dangerous drug in the fourth degree.
220.33 Criminal possession of a dangerous drug in the first degree.
220.35 Criminally selling a dangerous drug in the third degree.
220.40 Criminally selling a dangerous drug in the second degree.
220.44 Criminally selling a dangerous drug in the first degree.
220.45 Criminally possessing a hypodermic instrument.


§ 220.00 Dangerous drug offenses; definitions of terms

The following definitions are applicable to this article:

1. "Narcotic drug" means any drug, article or substance declared to be "narcotic drugs" in section three thousand three hundred one of the public health law.

2. "Depressant or stimulant drug" means any drug, article or substance declared to be a "depressant or stimulant drug" in section three thousand three hundred seventy-one of the public health law.

3. "Hallucinogenic drug" means any drug, article or substance declared to be "hallucinogenic drugs" in section two hundred twenty-nine of the mental hygiene law.

4. "Dangerous drug" means any narcotic drug, depressant or stimulant drug, or hallucinogenic drug.

5. "Sell" means to sell, exchange, give or dispose of to another, or to offer or agree to do the same.

6. "Unlawfully" means in violation of article thirty-three, article thirty-three-A, or article thirty-three-B of the public health law[1] or section two hundred twenty-nine of the mental hygiene law.

7. "Ounce" means an avoirdupois ounce as applied to solids and semi-solids, and a fluid ounce as applied to liquids. L.1965, c. 1030; amended L.1967, c. 791,§ 30, eff. September 1, 1967.

§ 220.05 Criminal possession of a dangerous drug in the sixth degree.

A person is guilty of criminal possession of a dangerous drug in the sixth degree when he knowingly and unlawfully possesses a dangerous drug.

Criminal possession of a dangerous drug in the sixth degree is a class A misdemeanor. L.1969, c.788, eff. September 1, 1969.

§ 220.10 Criminal possession of a dangerous drug in the fifth degree.

A person is guilty of criminal possession of a dangerous drug in the fifth degree when he knowingly and unlawfully possesses a dangerous drug with intent to sell the same. Criminal possession of a dangerous drug in the fifth degree is a class E felony. L.1969, c. 788, eff. Sept. 1,1969.

§ 220.15 Criminal possession of a dangerous drug in the fourth degree.

A person is guilty of criminal possession of a dangerous drug in the fourth degree when he knowingly and unlawfully possesses a narcotic drug:

1. With intent to sell the same; or

2. Consisting of (a) twenty-five or more cigarettes containing cannabis; or (b) one or more preparations, compounds, mixtures or substances of an aggregate weight of (i) one-eighth ounce or more, containing any of the respective alkaloids or salts of heroin, morphine or cocaine, or (ii) one-quarter ounce or more, containing any cannabis, or (iii) one-half ounce or more, containing raw or prepared opium, or (iv) one-half ounce or more, containing one or more than one of any of the other narcotic drugs.

Criminal possession of a dangerous drug in the fourth degree is a class D felony. L.1969, c.788, eff. Sept. 1, 1969.

§ 220.20 Criminal possession of a dangerous drug in the third degree.

A person is guilty of criminal possession of a dangerous drug in the third degree when he knowingly and unlawfully possesses a narcotic drug consisting of (a) one hundred or more cigarettes containing cannabis: or (b) one or more preparations, compounds, mixtures or substances of an aggregate weight of (i) one or more ounces, containing any of the respective alkaloids or salts of heroin, morphine, or cocaine, or (ii) one or more ounces, containing any cannabis, or (iii) two or more ounces, containing raw or prepared opium, or (iv) two or more ounces, containing one or more than one of any of the other narcotic drugs.

Criminal possession of a dangerous drug in the third degree is a class C felony. L.1969, c.788, eff. September 1, 1969.

§ 220.22 Criminal possession of a dangerous drug in the second degree.

A person is guilty of criminal possession of a dangerous drug in the second degree when he knowingly and unlawfully possesses a narcotic drug consisting of one or more preparations, compounds, mixtures or substances of an aggregate weight of eight ounces or more, containing any of the respective alkaloids or salts of heroin, morphine or cocaine, or containing raw or prepared opium.

Criminal possession of a dangerous drug in the second degree is a class B felony. L.1969, c.788, eff. September 1, 1969.

§ 220.25 Criminal possession of a dangerous drug: presumption.

The presence of a dangerous drug in an automobile, other than a public omnibus, is presumptive evidence of knowing possession thereof by each and every person in the automobile at the time such drug was found; except that such presumption does not apply (a) to a duly licensed operator of an automobile who is at the time operating it for hire in the lawful and proper pursuit of his trade, or (b) to any person in the automobile if one of them, having obtained the drug and not being under duress, is authorized to possess it and such drug is in the same container as when he received possession thereof, or (c) when the drug is concealed upon the person of one of the occupants. L. 1965, c.1030, eff. Sept. 1, 1967.

§ 220.30 Criminally selling a dangerous drug in the fourth degree.

A person is guilty of criminally selling a dangerous drug in the fourth degree when he knowingly and unlawfully sells a dangerous drug.
Criminally selling a dangerous drug in the fourth degree is a class D felony. L.1969, c. 787, eff. Sept. 1, 1969.

§ 220.33 Criminal possession of a dangerous drug in the first degree.

A person is guilty of criminal possession of a dangerous drug in the first degree when he knowingly and unlawfully possesses a narcotic drug consisting of one or more preparations, compounds, mixtures or substances of an aggregate weight of sixteen ounces or more containing any of the respective alkaloids or salts of heroin, morphine or cocaine, or containing raw or prepared opium.
Criminal possession of a dangerous drug in the first degree is a class A felony. L.1969, c. 788, eff. Sept. 1, 1969.

§ 220.35 Criminally selling a dangerous drug in the third degree.

A person is guilty of criminally selling a dangerous drug in the third degree when he knowingly and unlawfully sells a narcotic drug.
Criminally selling a dangerous drug in the third degree is a class C felony. L.1969, c. 787, eff. September 1, 1969.

§ 220.40 Criminally selling a dangerous drug in the second degree.

A person is guilty of criminally selling a dangerous drug in the second degree when he knowingly and unlawfully sells a narcotic drug:

1. To a person less than twenty-one years old; or

2. Consisting of one or more preparations, compounds, mixtures or substances of an aggregate weight of eight ounces or more, containing any of the respective alkaloids or salts of heroin, morphine or cocaine, or containing raw or prepared opium.

Criminally selling a dangerous drug in the second degree is a class B. felony. L.1969, c.787, eff.Sept. 1, 1969.

§ 220.44 Criminally selling a dangerous drug in the first degree.

A person is guilty of criminally selling a dangerous drug in the first degree when he knowingly and unlawfully sells a narcotic drug consisting of one or more preparations, compounds, mixtures or substances of an aggregate weight of sixteen ounces or more, containing any of the respective alkaloids or salts of heroin, morphine or cocaine, or containing raw or prepared opium.

Criminally selling a dangerous drug in the first degree is a class A felony. L. 1969, c.787, eff. Sept. 1, 1969.

§ 220.45 Criminally possessing a hypodermic instrument.

A person is guilty of criminally possessing a hypodermic instrument when he knowingly and unlawfully possesses or sells a hypodermic syringe or hypodermic needle.

Criminally possessing a hypodermic instrument is a class A misdemeanor. L.1965, c. 1030, eff. Sept. 1, 1967.

The following is a chart of possible sentences of imprisonmnent for the above crimes:

| Designation of Crime | Maximum Imprisonment | Minimum |
|---|---|---|
| Class A Misdemeanor | 1 year | |
| Class A Felony | Life Imprisonment | 15 years |
| Class B Felony | 25 years | 8 and 1/3 years |
| Class C Felony | 15 years | 5 years |
| Class D Felony | 7 years | 2 and 1/3 years |
| Class E Felony | 4 years | 1 year. |